Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MARCUS HAYES, DC

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-15-0514-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
OCTOBER 6, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The IC states in their EOB that 'a payment or denial has already been recommended for this service'. However, as stated in the request for reconsideration, no payment nor denial defining why the claim was denied was ever received. A request for reconsideration was submitted in an effort to receive payment or receive the basis for which payment was denied, however, the IC failed to respond."

Amount in Dispute: $499.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 16, 2014	CPT Code 97750-FC (10 units) Functional Capacity Evaluation (FCE)	$499.40	$499.40

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on October 15, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 247-A payment or denial has already been recommended for this service.

Issues

Is the requestor entitled to reimbursement for the FCE rendered on July 16, 2014?

Findings

This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204.

On the disputed date of service, the requestor billed CPT code 97750-FC.

The American Medical Association (AMA) Current Procedural Terminology (CPT) defines CPT code 97750 as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."

The requestor appended modifier "FC" to code 97750. 28 Texas Administrative Code §134.204(n)(3) states "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (3) FC, Functional Capacity-This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed".

28 Texas Administrative Code §134.204(g) states "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required."

A review of the submitted medical bill indicates that the requestor billed for ten units, which equals 2 1/2 hours. No documentation was submitted that the requestor exceeded the time limit set in 28 Texas Administrative Code §134.204(g) for disputed FCE.

Per 28 Texas Administrative Code §134.204(g) to determine the reimbursement for FCEs the Division refers to 28 Texas Administrative Code §134.203(c)(1)(2).

Per 28 Texas Administrative Code §134.203(c)(1)(2), the following formula is used to calculate the Maximum Allowable Reimbursement (MAR): (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = MAR.

The 2014 DWC conversion factor for this service is 55.75.

The Medicare Conversion Factor is 35.8228.

Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 78229 which is located in San Antonio, Texas; therefore, the Medicare locality is "Rest of Texas."

The Medicare participating amount for CPT code 97750 is $32.09.

Using the above formula, the MAR is $49.94 per unit. The requestor billed for 10 units; therefore, $49.94 X 10 = $499.40. The respondent paid $0.00. The difference between MAR and amount paid is $499.40; this amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $499.40.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $499.40 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	04/17/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.